STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675469	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Floresville Residence and Rehabilitation Center	1811 Sixth St Floresville, TX 78114

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 39251 Based on observation, interview, and record review, the facility failed to ensure the residents' right to personal privacy and confidentiality of his or her personal and medical records for 1 of 1 facility reviewed for privacy and confidentiality, in that: The confidential information of various residents was left in 3 clear plastic trash bags outside of the Medical Records office, and was left on top of a printer in area accessible to all staff, residents, and visitors. The findings included: 1. Observation on 8/6/24 at 9:45 a.m. revealed there were 3 clear trash bags outside of the Medical Records office. During an interview with LVN A on 8/6/24 at 9:45 a.m., at the same time as the observation, LVN A looked inside of each clear trash bag and confirmed that each clear trash bag contained confidential resident information. 2. Observation on 8/6/24 at 9:48 a.m. revealed there was a stack of papers were observed on top of a printer located in a T.V. lounge directly across from the Medical Records office. Further observation revealed a visitor was noted sitting in the lounge. During an interview with LVN A on 8/6/24 at 9:48 a.m., at the same time as the observation, LVN A reviewed the documentation on top of the printer and confirmed it contained confidential resident information. During interview with LVN A on 8/6/24 at 9:49 a.m., LVN A stated the area was accessible to residents wanting to watch T.V., as well as staff and visitors. LVN A further stated she did not know why this information was left in a public area and all staff were responsible for ensuring confidentiality. During an interview with LVN B on 8/7/24 at 2:59 p.m., LVN B stated all staff were responsible for maintaining confidentiality of resident records. LVN B further stated resident information was privileged information and it was important it be kept confidential because it was the law. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator on 8/8/24 at 11:00 a.m., the Administrator stated the trash bags had just been taken out of her office and taken to the medical records office for shredding, adding she was not aware of the papers left on top of the printer in the T.V. lounge. The Administrator stated it was important to maintain confidentiality of resident information, adding she and the DON were responsible for ensuring confidentiality of resident records. Record review of facility's policy, titled, Resident Rights, undated, revealed, . Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to . Privacy and confidentiality . Record review of facility's policy, titled, Protected Health Information (PHI), Management and Protection of, undated, revealed, . Protected Health Information (PHI) shall not be used or disclosed except as permitted by current federal and state laws . 1. It is the responsibility of all personnel who have access to resident and facility information to ensure that such information is managed and protected to prevent unauthorized release or disclosure .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observation, interview, and record review, the facility failed to ensure residents who were fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 1 of 2 residents (Resident #3) reviewed for gastrostomy tube management., in that: 1. LVN A failed to check the placement of Resident #3's PEG tube prior to administering flushes and medications. 2. LVN A failed to check Resident #3's gastric residual volume prior to administering flushes and medications via Resident #3's PEG tube. 3. LVN A failed to follow Resident #3's order for flushes when administering flushes and medication via Resident #3's PEG tube. 4. LVN A failed to administer medications and flushes via Resident #3's PEG tube using gravity. These failures could place residents with gastrostomy tubes at risk of aspiration, medical complications, and a decline in health due to inappropriate gastrostomy tube care and management. The findings included: Record review of Resident #3's Quarterly MDS assessment, dated 7/6/24, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: stroke (an area of the brain that dies due to lack of blood flow), hypertension (high blood pressure), neurogenic bladder (lack bladder control due to a brain, spinal cord, or nerve problem), type 2 diabetes (condition in which the body has trouble controlling blood sugar and using it for energy) , gastrostomy status (surgical opening into the stomach from the for the introduction of food). Further review of this MDS revealed Resident #3's cognitive skills for daily decision making was severely impaired and was dependent (helper does all the effort. Resident does none of the effort to complete the activity) when eating. Record review of Resident #3's Care Plan dated, revised 12/5/23, revealed: [Resident #3] requires tube feeding r/t CVA effecting swallowing abilities/dysphagia .The resident is dependent on staff with tube feeding and water flushes .Check for tube placement and gastric contents/residual volume . Record review of Resident #3's Physician Orders revealed the following orders: Baclofen oral tablet 5 mg, give 1 tablet via PEG tube three times a day for muscle spasms; dated 8/1/23; Gabapentin oral capsule 100 mg, give 2 capsules via PEG tube three times a day related to malaise, dated 2/1/24; Reglan oral tablet 5 mg, give 1 tablet via PEG tube five times a day for GERD (digestive disease in which stomach acid or bile irritates the food pipe lining), dated 8/1/23; Levothyroxine tablet 112 mcg, give 1 tablet via PEG tube every 24 hours for low thyroid hormone, dated 7/20/24; Tramadol tablet 50 mg, give 1 tablet via PEG tube two times a day for pain and 1 tablet every 4 hours as needed for pain, dated 4/3/24; Flush enteral tube with 30 mL water pre/post medication administration and 5-10 mL water between each medication, dated 2/15/24. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview during medication administration on 8/6/24 beginning at 3:31 p.m., LVN A prepared Resident #3's medication. LVN A sanitized her hands, donned gloves, and popped the following medication from the blister packs after verifying each with the eMAR: Baclofen 5 mg, Gabapentin 100 mg (2 capsules), Reglan 5 mg, Levothyroxine 112 mcg, and Tramadol 50 mg. LVN A crushed all the medications and opened the Gabapentin capsules, placing each medication into separate medication cups. LVN A obtained water from the bathroom sink and pushed 30 cc of water into Resident #3's PEG tube using syringe, mixed one of the medications with 20 cc of water, and pushed it into Resident #3's PEG tube, she mixed second medication with 25 cc of water, LVN A said he received 30 cc flush in between each medication, and pushed it into Resident #3's PEG tube, she then pushed 30 cc of water into the PEG tube, LVN A mixed a third medication with 20 cc of water and pushed it into Resident #3's PEG tube, she then pushed 30 cc of water, she mixed forth medication with 25 cc of water and pushed it into Resident #3's PEG tube, she then pushed 30 cc of water, she mixed fifth medication with 20 cc of water and pushed it into Resident #3's PEG tube. LVN A then flushed Resident #3's PEG tube with 200 cc of water by pushing 60 cc of water 3 times and then 20 cc. During interview with LVN A on 8/6/24 at 4:21 p.m., LVN A stated she had not received training regarding PEG tubes at the facility because she had been a nurse for 9 years. LVN A further stated it was important to administer medications and water via PEG tubes using gravity because air could be pushed into the resident's stomach causing upset. LVN A stated she did not believe Resident #3 had an order to check residuals/placement, and further stated Resident #3 was not able to verbalize if his stomach was full or felt bloated. LVN A stated the facility currently did not have a DON. During interview with LVN B on 8/7/24 at 2:59 p.m., LVN B stated medications and water flushes were administered using gravity and nurses were required to check PEG tubes for placement and residual volume, adding she guessed it was policy. LVN B further stated it was facility policy to check PEG tube placement prior to administering anything via a PEG tube. LVN B stated checking for placement was important because if the tube was not in the proper place the resident may be harmed and it was important to check for residual volume to ensure the residents were digesting properly. LVN B stated the facility currently did not have a DON. Record review of facility's policy titled Administering Medications through an Enteral Tube, undated, revealed: .2. Review the resident's care plan to assess for any special needs of the resident .Steps in the Procedure .13. Assess the resident, as indicated .19. Check gastric residual volume (GRV) to assess for tolerance of enteral feeding. 20. When correct tube placement and acceptable GRV have been verified, flush tubing with 15-30 mL warm sterile water (or prescribed amount) .22. Dilute the crushed or split medication with 15-30 mL of water or per physician orders. 23. Reattach [NAME] (without plunger) to the end of the tubing. 24. Administer medication by gravity flow. a. Pour diluted medication into the barrel of the syringe while holding the tubing slightly above the level of insertion. b. Open the clamp and deliver medication slowly .25. If administering more than one medication, flush with 15 mL (or prescribed amount) warm water between medications. 26. When the last of the medication begins to drain from the tubing, flush the tubing with 15 mL of warm water (or prescribed amount) . (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Roecord review of webite Nursing 2024, article titled Administering medication through a gastrostomy tube, dated December 2022, revealed: .Release the GT clamp. To verify tube placement and patency, aspirate for gastric contents, note the residual volume, and follow your facility's policy for reinstilling it . let the water flow by gravity to flush it .Pour the diluted medication into the syringe and release the tubing to administer it. If you're giving more than one drug, flush between each dose with 15 to 30 ml of water. When finished, flush with 30 ml of water, clamp the GT, and replace the plug .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals, in accordance with State and Federal laws, were stored in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for 1 of 2 residents (Resident #5) reviewed for storage of drugs, in that: The facility failed to ensure Resident #5's medications were secured when LVN C left Resident #5's room prior to administering medications. This failure could place residents at risk of medication misuse and diversion. The findings included: Record review of Resident #5's Comprehensive MDS assessment, dated 6/22/24, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: acute respiratory failure, congestive heart failure (condition in which the heart can't pump blood well enough to meet the body's needs) bradycardic (week pulse), deep vein thrombosis of left upper arm (a blood clot in a deep vein), atrial fibrillation (An irregular, often rapid heart rate that commonly causes poor blood flow), and hypertension (high blood pressure). Further review of this MDS revealed Resident #3's cognitive skills for daily decision making was severely impaired. Record review of Resident #5's Physician Orders revealed the following orders: Morphine oral solution 20 mg/mL, give 0.25 mL orally every 4 hours for pain, may give sublingual, dated 8/6/24; Tramadol oral tablet 50 mg, give 1 tablet via PEG tube every 6 hours for pain, dated 8/2/24; Lorazepam oral concentrate 2 mg/mL, give 0.5 mL orally every 6 hours related to restlessness and agitation, dated 8/2/24. During an observation and interview on 8/6/24 at beginning at 12:38 p.m., LVN C prepared Resident #5's medications. LVN C removed Morphine 20 mg/mL and Tramadol 50 mg from the locked box. LVN C then crushed the Tramadol, labeled cup with Tramadol and placed medication into the medication cup. LVN C then retrieved Lorazepam 2 mg/mL from the refrigerator in the medication room and drew up 0.5 mL using syringe and placed in medication cup and labeled cup Lorazepam. LVN C placed medications on bedside table and went into the bathroom and washed her hands. LVN C left Resident #5's room at 12:50 p.m. leaving the medications on the bedside table. LVN C returned, performed hand hygiene, drew up morphine 0. 25 mL with syringe, and administered under Resident #5's tongue. LVN C checked Resident #5's residual volume and PEG tube placement and administered medications and water flushes via gravity. LVN C stated she was not supposed to leave medication in resident rooms unattended because staff, visitors, or another resident may have taken them. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN B on 8/7/24 at 2:59 a.m., LVN B stated it was facility policy that medications were not be left unattended because somebody could take them, and it could cause harm. LVN B further stated the nurse administering the medications was responsible for ensuring medications were secured. LVN B stated she and the DON were responsible for ensuring nurses followed proper procedures. LVN B stated the facility currently did not have a DON. Record review of facility's policy titled Storage of Medications, dated 1/1/2024, revealed: .The facility shall store all drugs and biologicals in a safe, secure, and orderly manner .2. the nursing staff shall be responsible for maintaining medication storage .in a clean, safe, and sanitary manner . Record review of the facility policy titled, Controlled Substances, undated, revealed: .The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances.